



General Assembly

January Session, 2009

Raised Bill No. 958

LCO No. 2972

02972_____INS

Referred to Committee on Insurance and Real Estate

Introduced by:
(INS)

AN ACT CONCERNING UTILIZATION REVIEW.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

1 Section 1. Section 38a-226 of the general statutes is repealed and the
2 following is substituted in lieu thereof (*Effective January 1, 2010*):

3 For purposes of sections 38a-226 to 38a-226d, inclusive, as amended
4 by this act:

5 (1) "Utilization review" means the prospective, [or] concurrent or
6 retrospective assessment of the necessity and appropriateness of the
7 allocation of health care resources and services given or proposed to be
8 given to an individual within this state. [Utilization review shall not
9 include elective requests for clarification of coverage.]

10 (2) "Utilization review company" means any company, organization
11 or other entity performing utilization review, except:

12 (A) An agency of the federal government;

13 (B) An agent acting on behalf of the federal government, but only to
14 the extent that the agent is providing services to the federal

15 government;

16 (C) Any agency of the state of Connecticut; or

17 (D) A hospital's internal quality assurance program except if
18 associated with a health care financing mechanism.

19 (3) "Adverse determination" means a utilization review company's
20 decision that an admission, service, procedure or extension of stay is
21 not medically necessary.

22 [(3)] (4) "Commissioner" means the Insurance Commissioner.

23 (5) "Concurrent determination" means a utilization review
24 company's decision of the medical necessity of an admission, service,
25 procedure or extension of stay while such admission, service,
26 procedure or extension of stay is being provided.

27 [(4)] (6) "Enrollee" means an individual [who has contracted for or]
28 patient who participates in coverage under an insurance policy, a
29 health care center contract, an employee welfare benefits plan, a
30 hospital or medical services plan contract or any other benefit program
31 providing payment, reimbursement or indemnification for health care
32 costs for an individual or his eligible dependents.

33 (7) "Enrollee's representative" means a legal guardian or agent of an
34 enrollee.

35 (8) "Final adjudication" means a utilization review company's
36 decision that is not subject to any further internal appeal.

37 (9) "Medically necessary" or "medical necessity" means health care
38 services that a physician, exercising prudent clinical judgment, would
39 provide to a patient for the purpose of preventing, evaluating,
40 diagnosing or treating an illness, injury, disease or its symptoms, and
41 that are: (A) In accordance with generally accepted standards of
42 medical practice; (B) clinically appropriate, in terms of type, frequency,

43 extent, site and duration and considered effective for the patient's
 44 illness, injury or disease; and (C) not primarily for the convenience of
 45 the patient, physician or other health care provider and not more
 46 costly than an alternative service or sequence of services at least as
 47 likely to produce equivalent therapeutic or diagnostic results as to the
 48 diagnosis or treatment of that patient's illness, injury or disease. For
 49 the purposes of this subdivision, "generally accepted standards of
 50 medical practice" means standards that are based on credible scientific
 51 evidence published in peer-reviewed medical literature generally
 52 recognized by the relevant medical community or otherwise consistent
 53 with the standards set forth in policy issues involving clinical
 54 judgment.

55 (10) "Prospective determination" means a utilization review
 56 company's decision of the medical necessity of an admission, service,
 57 procedure or extension of stay to be provided to the enrollee.

58 [(5)] (11) "Provider of record" or "provider" means the physician or
 59 other licensed practitioner identified to the utilization review [agent]
 60 company as having primary responsibility for the care, treatment and
 61 services rendered to an individual.

62 (12) "Retrospective determination" means a utilization review
 63 company's decision of the medical necessity of an admission, service,
 64 procedure or extension of stay that has been provided to the enrollee.

65 Sec. 2. Subsection (a) of section 38a-226c of the general statutes is
 66 repealed and the following is substituted in lieu thereof (*Effective*
 67 *January 1, 2010*):

68 (a) All utilization review companies shall meet the following
 69 minimum standards:

70 (1) Each utilization review company shall maintain and make
 71 available procedures for [providing notification of] its determinations
 72 [regarding certification] in accordance with the following:

73 (A) [Notification] (i) Written notification of any prospective,
74 concurrent or retrospective determination by the utilization review
75 company shall be mailed or otherwise communicated to [the provider
76 of record or] the enrollee, [or other appropriate individual within] the
77 enrollee's representative or the provider of record not later than two
78 business days [of] after the receipt of all information necessary to
79 complete the review. [, provided any determination not to certify an
80 admission, service, procedure or extension of stay shall be in writing.]

81 (ii) In addition to providing written notification of a determination,
82 the utilization review company may give authorization orally or
83 through a communication other than in writing. If the determination is
84 an approval for a request, the company shall provide a confirmation
85 number corresponding to the authorization.

86 (B) (i) After a prospective determination that authorizes an
87 admission, service, procedure or extension of stay has been
88 communicated by the utilization review company to the [appropriate
89 individual, based on accurate information from the] enrollee or the
90 enrollee's representative and the enrollee's provider, the utilization
91 review company [may] shall not reverse such determination if such
92 admission, service, procedure or extension of stay has taken place in
93 reliance on such determination, unless the determination was based on
94 inaccurate information from the provider.

95 (ii) Regardless of whether a prospective determination is required
96 by contract, a utilization review company shall provide such
97 prospective determination upon request by an enrollee, an enrollee's
98 representative or an enrollee's provider.

99 [(B) Notification of a concurrent determination shall be mailed or
100 otherwise communicated to the provider of record within two business
101 days of receipt of all information necessary to complete the review or,
102 provided all information necessary to perform the review has been
103 received, prior to the end of the current certified period and provided
104 any determination not to certify an admission, service, procedure or

105 extension of stay shall be in writing.]

106 (C) [The utilization review company shall not make a determination
107 not to certify based on incomplete information unless it has clearly
108 indicated, in writing, to the provider of record or the enrollee all the
109 information that is needed to make such determination.] If an
110 enrollee's provider requests a concurrent determination, the utilization
111 review company shall provide, if requested by such provider, an
112 opportunity for such provider to discuss the request for concurrent
113 determination with the health care professional making the decision.

114 (D) [Notwithstanding subparagraphs (A) to (C), inclusive, of this
115 subdivision, the utilization review company may give authorization
116 orally, electronically or communicated other than in writing. If the
117 determination is an approval for a request, the company shall provide
118 a confirmation number corresponding to the authorization.] If an
119 enrollee, an enrollee's representative or an enrollee's provider requests
120 a prospective or retrospective determination and the utilization review
121 company does not possess all the information necessary to make such
122 determination, the utilization review company shall request from the
123 appropriate individual all such information in writing it requires and
124 shall provide a copy of such request to the enrollee or the enrollee's
125 representative. The utilization review company shall maintain a record
126 of all such requests for additional information. The utilization review
127 company shall not issue any notification declining certification or
128 authorization of an admission, service, procedure or extension of stay
129 prior to receiving and evaluating the requested information, and shall
130 not render a determination based on a lack of necessary information
131 without having first issued a written request for additional
132 information and providing a reasonable opportunity to comply with
133 such request.

134 (E) [Except as provided in subparagraph (F) of this subdivision with
135 respect to a final notice, each] Each notice of a determination not to
136 certify or authorize an admission, service, procedure or extension of

137 stay shall include in writing (i) the principal reasons for the
138 determination, (ii) the procedures to initiate an appeal of the
139 determination or the name and telephone number of the person to
140 contact with regard to an appeal pursuant to the provisions of this
141 section, or a statement that all applicable internal appeals have been
142 exhausted, and (iii) the procedure to appeal to the commissioner
143 pursuant to section 38a-478n, as amended by this act.

144 (F) [Each notice of a final determination not to certify an admission,
145 service, procedure or extension of stay shall include in writing (i) the
146 principal reasons for the determination, (ii) a statement that all internal
147 appeal mechanisms have been exhausted, and (iii) a copy of the
148 application and procedures prescribed by the commissioner for filing
149 an appeal to the commissioner pursuant to section 38a-478n.] Any
150 adverse determination shall be made by a licensed health care
151 professional. Except for final adjudications as set forth in
152 subparagraph (F) of subdivision (2) of this subsection, physicians,
153 nurses and other licensed health care professionals making utilization
154 review decisions shall have current licenses from a state licensing
155 agency in the United States or appropriate certification from a
156 recognized accreditation agency in the United States.

157 (2) Each utilization review company shall maintain and make
158 available a written description of the [appeal procedure] utilization
159 review company's procedures for appeals by which [either] the
160 enrollee, the enrollee's representative or the provider of record may
161 seek review of determinations not to certify or authorize an admission,
162 service, procedure or extension of stay. The procedures for appeals
163 shall include the following:

164 (A) Each utilization review company shall notify in writing the
165 enrollee or enrollee's representative and provider of record of its
166 [determination on] adjudication of the appeal as soon as practical, but
167 in no case later than [thirty] fifteen days after receiving the required
168 documentation on the appeal.

169 (B) On appeal, all determinations not to certify or authorize an
170 admission, service, procedure or extension of stay shall be made by a
171 licensed practitioner of the healing arts who has a current license from
172 a state licensing agency in the United States or appropriate certification
173 from a recognized accreditation agency in the United States.

174 (C) An appeal filed by an enrollee's provider shall not preclude such
175 enrollee or enrollee's representative from filing a separate appeal of the
176 same determination.

177 [(3)] (D) The process established by each utilization review company
178 [may] shall include a reasonable period within which an appeal [must
179 be filed to be considered] shall be filed, provided such period is not
180 less than ninety days after the issuance of the determination. Any such
181 period may be extended by the utilization review company upon a
182 showing of a justifiable reason for the enrollee's failure or inability to
183 request an appeal in a timely fashion, including, but not limited to,
184 illness, incapacity, hospitalization or failure to receive the
185 determination within the time period set forth in this section.

186 [(4)] (E) Each utilization review company shall also provide for an
187 expedited appeals process for emergency or [life threatening] life-
188 threatening situations, as determined by the enrollee's provider. Each
189 utilization review company shall complete the adjudication of such
190 expedited appeals [within two] not later than one business [days of]
191 day after the date the appeal is filed and all information necessary to
192 complete the appeal is received by the utilization review company. If
193 the utilization review company does not possess all information
194 necessary to complete the appeal, the utilization review company shall
195 request from the appropriate individual all such information in writing
196 it requires and shall provide a copy of such request to the enrollee or
197 the enrollee's representative. The utilization review company shall
198 maintain a record of all such requests for additional information. The
199 utilization review company shall not render an adjudication based on
200 a lack of necessary information without first having issued a written

201 request for additional information and providing a reasonable
202 opportunity to comply with such request.

203 (F) (i) If the appeal is for a final adjudication, the utilization review
204 company shall, at its expense, have the case reviewed by a physician
205 who is a specialist in the same specialty or subspecialty as the provider
206 of the requested treatment. Except as set forth in subparagraph (E) of
207 this subdivision, such review shall be completed not later than thirty
208 days after the date such review was requested by the utilization review
209 company. The reviewing physician shall issue a written report of the
210 findings to the utilization review company, which shall maintain
211 documentation of such review for the commissioner's verification,
212 including the name of such reviewing physician.

213 (ii) Except for a claim brought pursuant to chapter 568, a final
214 adjudication that upholds an adverse determination shall have been
215 made by a physician, nurse or other licensed health care professional
216 who is under the authority of a physician, nurse or other licensed
217 health care professional who holds a current Connecticut license from
218 the Department of Public Health.

219 (iii) Upon request by an enrollee, an enrollee's representative or an
220 enrollee's provider, the utilization review company shall provide a
221 hearing prior to the final adjudication of an appeal. Such hearing may
222 be conducted in person, by telephone or by other means at the
223 enrollee's discretion.

224 (I) The enrollee, the enrollee's representative, the enrollee's provider
225 and such other persons as requested by the enrollee may participate in
226 such hearing.

227 (II) The reviewing physician specified in subparagraph (F)(i) of this
228 subdivision shall participate in such hearing.

229 (III) Voting members of the utilization review company's review
230 panel shall participate in such hearing and in the deliberations on the

231 final adjudication.

232 (IV) No other person shall participate in such hearing or
233 deliberations unless approved by the enrollee or the enrollee's
234 representative and the utilization review company.

235 (iv) The utilization review company shall prepare a video or audio
236 recording of such hearing and shall provide a copy of such recording
237 to the enrollee or the enrollee's representative and the enrollee's
238 provider if such enrollee, enrollee's representative or enrollee's
239 provider appeals the final adjudication to the commissioner pursuant
240 to section 38a-478n, as amended by this act.

241 (G) If an adjudication upholds a determination not to certify or
242 authorize an admission, service, procedure or extension of stay, the
243 utilization review company shall notify the enrollee or the enrollee's
244 representative and the enrollee's provider in writing of such
245 adjudication. Such notification shall include: (i) The principal reasons
246 for the adjudication, provided in the case of an adverse determination,
247 the utilization review company shall include the specific reasons why
248 the admission, service, procedure or extension of stay is not medically
249 necessary, along with a summary of all information relied upon in
250 making such a finding; (ii) the procedures to initiate an appeal of such
251 adjudication or the name and telephone number of the person to
252 contact with regard to an appeal pursuant to the provisions of this
253 section; and (iii) in the case of a final adjudication, the procedure to
254 appeal to the commissioner pursuant to section 38a-478n, as amended
255 by this act.

256 [(5)] (3) Each utilization review company shall utilize written
257 clinical criteria and review procedures [which] that are established and
258 periodically evaluated and updated with appropriate involvement
259 from practitioners. Such criteria and procedures shall be consistent
260 with the definition of "medical necessity" set forth in section 38a-226,
261 as amended by this act, and such definition shall control in the event of
262 a conflict.

263 [(6) Physicians, nurses and other licensed health professionals
264 making utilization review decisions shall have current licenses from a
265 state licensing agency in the United States or appropriate certification
266 from a recognized accreditation agency in the United States, provided,
267 any final determination not to certify an admission, service, procedure
268 or extension of stay for an enrollee within this state, except for a claim
269 brought pursuant to chapter 568, shall be made by a physician, nurse
270 or other licensed health professional under the authority of a
271 physician, nurse or other licensed health professional who has a
272 current Connecticut license from the Department of Public Health.

273 (7) In cases where an appeal to reverse a determination not to certify
274 is unsuccessful, each utilization review company shall assure that a
275 practitioner in a specialty related to the condition is reasonably
276 available to review the case. When the reason for the determination not
277 to certify is based on medical necessity, including whether a treatment
278 is experimental or investigational, each utilization review company
279 shall have the case reviewed by a physician who is a specialist in the
280 field related to the condition that is the subject of the appeal. Any such
281 review, except for a claim brought pursuant to chapter 568, that
282 upholds a final determination not to certify in the case of an enrollee
283 within this state shall be conducted by such practitioner or physician
284 under the authority of a practitioner or physician who has a current
285 Connecticut license from the Department of Public Health. The review
286 shall be completed within thirty days of the request for review. The
287 utilization review company shall be financially responsible for the
288 review and shall maintain, for the commissioner's verification,
289 documentation of the review, including the name of the reviewing
290 physician.]

291 [(8)] (4) Except as provided in subsection (e) of this section, each
292 utilization review company shall make review staff available by toll-
293 free telephone, at least forty hours per week during normal business
294 hours.

295 [(9)] (5) Each utilization review company shall comply with all
296 applicable federal and state laws to protect the confidentiality of
297 individual medical records. Summary and aggregate data shall not be
298 considered confidential if [it does] they do not provide sufficient
299 information to allow identification of individual patients.

300 [(10)] (6) Each utilization review company shall allow a minimum of
301 twenty-four hours following an emergency admission, service or
302 procedure for an enrollee or his representative to notify the utilization
303 review company and request certification or continuing treatment for
304 that condition.

305 [(11)] (7) No utilization review company [may] shall give an
306 employee any financial incentive based on the number of denials of
307 certification such employee makes.

308 [(12)] (8) Each utilization review company shall annually file with
309 the commissioner:

310 (A) The names of all managed care organizations, as defined in
311 section 38a-478, as amended by this act, that the utilization review
312 company services in Connecticut;

313 (B) Any utilization review services for which the utilization review
314 company has contracted out for services and the name of such
315 company providing the services;

316 (C) The number of utilization review determinations not to certify
317 an admission, service, procedure or extension of stay and the outcome
318 of such determination upon appeal within the utilization review
319 company. Determinations related to mental or nervous conditions, as
320 defined in section 38a-514, shall be reported separately from all other
321 determinations reported under this subdivision; and

322 (D) The following information relative to requests for utilization
323 review of mental health services for enrollees of fully insured health
324 benefit plans or self-insured or self-funded employee health benefit

325 plans, separately and by category: (i) The reason for the request,
326 including, but not limited to, an inpatient admission, service,
327 procedure or extension of inpatient stay or an outpatient treatment, (ii)
328 the number of requests denied by type of request, and (iii) whether the
329 request was denied or partially denied.

330 [(13) Any utilization review decision to initially deny services shall
331 be made by a licensed health professional.]

332 Sec. 3. Section 38a-478 of the general statutes is repealed and the
333 following is substituted in lieu thereof (*Effective January 1, 2010*):

334 As used in sections 38a-478 to 38a-478o, inclusive, as amended by
335 this act, and subsection (a) of section 38a-478s:

336 (1) "Commissioner" means the Insurance Commissioner.

337 (2) "Managed care organization" means an insurer, health care
338 center, hospital or medical service corporation or other organization
339 delivering, issuing for delivery, renewing or amending any individual
340 or group health managed care plan in this state.

341 (3) "Managed care plan" means a product offered by a managed care
342 organization that provides for the financing or delivery of health care
343 services to persons enrolled in the plan through: (A) Arrangements
344 with selected providers to furnish health care services; (B) explicit
345 standards for the selection of participating providers; (C) financial
346 incentives for enrollees to use the participating providers and
347 procedures provided for by the plan; or (D) arrangements that share
348 risks with providers, provided the organization offering a plan
349 described under subparagraph (A), (B), (C) or (D) of this subdivision is
350 licensed by the Insurance Department pursuant to chapter 698, 698a or
351 700 and that the plan includes utilization review pursuant to sections
352 38a-226 to 38a-226d, inclusive, as amended by this act.

353 (4) "Provider" means a person licensed to provide health care
354 services under chapters 370 to 373, inclusive, 375 to 383c, inclusive,

355 384a to 384c, inclusive, or chapter 400j.

356 (5) Except as provided in sections 38a-478m and 38a-478n, "enrollee"
357 means a person who has contracted for or who participates in a
358 managed care plan for [himself] such person or [his] such person's
359 eligible dependents.

360 (6) "Preferred provider network" means a preferred provider
361 network, as defined in section 38a-479aa, as amended by this act.

362 (7) "Utilization review" [means utilization review, as defined] has
363 the same meaning as provided in section 38a-226, as amended by this
364 act.

365 (8) "Utilization review company" [means a utilization review
366 company, as defined] has the same meaning as provided in section
367 38a-226, as amended by this act.

368 Sec. 4. Subsections (a) and (b) of section 38a-478n of the general
369 statutes are repealed and the following is substituted in lieu thereof
370 (*Effective January 1, 2010*):

371 (a) Any enrollee, or any provider acting on behalf of an enrollee
372 with the enrollee's consent, who has exhausted the internal
373 mechanisms provided by a managed care organization, health insurer
374 or utilization review company to appeal the denial of a claim based on
375 medical necessity or a determination not to certify or authorize an
376 admission, service, procedure or extension of stay, regardless of
377 whether such determination was made before, during or after the
378 admission, service, procedure or extension of stay, may appeal such
379 denial or determination to the commissioner. As used in this section
380 and section 38a-478m, "health insurer" means any entity, other than a
381 managed care organization [, which] that delivers, issues for delivery,
382 renews, [or] amends or continues an individual or group health plan in
383 this state [, "health plan" means a plan of health insurance] providing
384 coverage of the type specified in subdivision (1), (2), (4), (10), (11), (12)

385 and (13) of section 38a-469, [but does not include a managed care plan
386 offered by a managed care organization,] and "enrollee" means a
387 person who has contracted for or who participates in coverage under
388 an individual or group health insurance plan or a managed care plan
389 [or health plan for himself or his] for such person or such person's
390 eligible dependents.

391 (b) (1) To appeal a denial or determination pursuant to this section
392 an enrollee or any provider acting on behalf of an enrollee shall, not
393 later than sixty days after receiving final written notice of the denial or
394 determination from the enrollee's managed care organization, health
395 insurer or utilization review company, file a written request with the
396 commissioner. The appeal shall be on forms prescribed by the
397 commissioner and shall include the filing fee set forth in subdivision
398 (2) of this subsection and a general release executed by the enrollee for
399 all medical records pertinent to the appeal. The managed care
400 organization, health insurer or utilization review company named in
401 the appeal shall also pay to the commissioner the filing fee set forth in
402 subdivision (2) of this subsection. If the Insurance Commissioner
403 receives three or more appeals of denials or determinations by the
404 same managed care organization or utilization review company with
405 respect to the same procedural or diagnostic coding, the Insurance
406 Commissioner may, on said commissioner's own motion, issue an
407 order specifying how such managed care organization or utilization
408 review company shall make determinations about such procedural or
409 diagnostic coding.

410 (2) The filing fee for a managed care organization, health insurer or
411 utilization review company shall be twenty-five dollars and shall be
412 deposited in the Insurance Fund established in section 38a-52a. [If the
413 commissioner finds that an enrollee is indigent or unable to pay the
414 fee, the commissioner shall waive the enrollee's fee.] The commissioner
415 shall refund any paid filing fee to [(A)] the managed care organization,
416 health insurer or utilization review company if the appeal is not
417 accepted for full review, or [(B)] such managed care organization,

418 health insurer or utilization review company is the prevailing party
419 upon completion of a full review pursuant to this section.

420 (3) Upon receipt of the appeal together with the executed release
421 and appropriate fee, the commissioner shall assign the appeal for
422 review to an entity as defined in subsection (c) of this section.

423 (4) Upon receipt of the request for appeal from the commissioner,
424 the entity conducting the appeal shall conduct a preliminary review of
425 the appeal and accept the appeal if such entity determines: (A) The
426 individual was or is an enrollee of the managed care organization or
427 health insurer; (B) the benefit or service that is the subject of the
428 complaint or appeal reasonably appears to be a covered service, benefit
429 or service under the agreement provided by contract to the enrollee;
430 (C) the enrollee has exhausted all internal appeal mechanisms
431 provided; (D) the enrollee has provided all information required by the
432 commissioner to make a preliminary determination including the
433 appeal form, a copy of the final decision of denial and a fully-executed
434 release to obtain any necessary medical records from the managed care
435 organization or health insurer and any other relevant provider.

436 (5) Upon completion of the preliminary review, the entity
437 conducting such review shall immediately notify the member or
438 provider, as applicable, in writing as to whether the appeal has been
439 accepted for full review and, if not so accepted, the reasons why the
440 appeal was not accepted for full review.

441 (6) If accepted for full review, the entity shall conduct such review
442 in accordance with the regulations adopted by the commissioner, after
443 consultation with the Commissioner of Public Health, in accordance
444 with the provisions of chapter 54.

445 Sec. 5. Subsection (m) of section 38a-479aa of the general statutes is
446 repealed and the following is substituted in lieu thereof (*Effective*
447 *January 1, 2010*):

448 (m) Each utilization review determination made by or on behalf of a
 449 preferred provider network shall be made in accordance with sections
 450 38a-226 to 38a-226d, inclusive, [except that any] as amended by this
 451 act. Any initial appeal of a determination not to certify an admission,
 452 service, procedure or extension of stay shall be conducted in
 453 accordance with subdivision [(7)] (2) of subsection (a) of section 38a-
 454 226c, as amended by this act, and any subsequent appeal shall be
 455 referred to the managed care organization on whose behalf the
 456 preferred provider network provides services. The managed care
 457 organization shall conduct the subsequent appeal in accordance with
 458 said subdivision.

459 Sec. 6. Subdivision (12) of subsection (d) of section 38a-479bb of the
 460 general statutes is repealed and the following is substituted in lieu
 461 thereof (*Effective January 1, 2010*):

462 (12) A provision that the preferred provider network shall ensure
 463 that utilization review determinations are made in accordance with
 464 sections 38a-226 to 38a-226d, inclusive, [except that any] as amended
 465 by this act. Any initial appeal of a determination not to certify an
 466 admission, service, procedure or extension of stay shall be made in
 467 accordance with subdivision [(7)] (2) of subsection (a) of section 38a-
 468 226c, as amended by this act. In cases where an appeal to reverse a
 469 determination not to certify is unsuccessful, the preferred provider
 470 network shall refer the case to the managed care organization which
 471 shall conduct the subsequent appeal, if any, in accordance with said
 472 subdivision.

This act shall take effect as follows and shall amend the following sections:		
Section 1	<i>January 1, 2010</i>	38a-226
Sec. 2	<i>January 1, 2010</i>	38a-226c(a)
Sec. 3	<i>January 1, 2010</i>	38a-478
Sec. 4	<i>January 1, 2010</i>	38a-478n(a) and (b)
Sec. 5	<i>January 1, 2010</i>	38a-479aa(m)

Sec. 6	<i>January 1, 2010</i>	38a-479bb(d)(12)
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Statement of Purpose:

To clarify the requirements and standards for utilization review companies and the reviews such companies perform.

[Proposed deletions are enclosed in brackets. Proposed additions are indicated by underline, except that when the entire text of a bill or resolution or a section of a bill or resolution is new, it is not underlined.]